PRE-APPLICATION TO MEDICAL STAFF

The purpose of this questionnaire is to verify that your credentials are in good standing with the appropriate licensing board, National Practitioner Data Bank, and other associations before an authorized approval and hiring determination is made.

All licensed independent practitioner applicants who are applying for the positions listed below, or the equivalent of those positions, must complete this form. **Fax the completed form, along with your CURRENT Curriculum Vitae and other requested documents, to the California Department of Corrections and Rehabilitation (CDCR) Credential Coordinator at (916) 324-6763.** If you have any questions, the agent may be reached by telephone at (916) 327-3336.

TO PREVENT UNNECESSARY DELAYS IN PROCESSING YOUR APPLICATION, PLEASE PRINT LEGIBLY AND PROVIDE ALL REQUESTED INFORMATION.

Application for the Position of: ☐ **Physician & Surgeon** ☐ **Chief Medical Officer**
☐ **Physician & Surgeon (Internal Medicine/Family Practice)**
☐ **Chief Physician & Surgeon** ☐ **Chief Deputy, Clinical Services**

Name: Last: _____ First: _____ Middle: _____

Other Names Used: _____ Gender: ☐ Female ☐ Male

Full Social Security Number: _____ Date of Birth: _____

Home Address: _____
Street Address City State Zip Code

Contact Information: _____
e-mail address phone numbers

United States Citizen: ☐ Yes ☐ No. If no, what kind of visa will you hold while you are here?

Type: _____ Sponsor: _____ Expiration Date: _____

If you hold permanent immigrant status in the U.S., please attach a copy of your green card or approval letter.

National Identification number: _____ Country of Issue _____

Professional school(s) (nursing or medical degrees):

Name	Degree	Year Graduated

Professional license(s)/certifications/registrations (medical, nurse practitioner, physician assistant):

License number: _____ State: _____ License number: _____ State: _____
License number: _____ State: _____ License number: _____ State: _____
License number: _____ State: _____ License number: _____ State: _____

Name of Specialty Residency _____

Board eligible: ☐ Yes ☐ No If Yes, name of Board: _____

Board certified: ☐ Yes ☐ No If Yes, Board: _____

Most recent year certified/recertified: _____

DEA Number: _____ Expiration Date: _____

BLS Certification: _____ Expiration Date: _____
(Please attach a copy the certificate to this application)

ANY AFFIRMATIVE ANSWER TO QUESTIONS ONE THROUGH 18 REQUIRES ADDITIONAL INFORMATION ON A SEPARATE PIECE OF PAPER, ELABORATING UPON THE RESPONSE AND DESCRIBING THE CIRCUMSTANCES INVOLVED.

1. Have any disciplinary actions been initiated or are any pending against you by any state licensure board? □ Yes □ No
2. Has your license to practice in any state ever been relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily? □ Yes □ No
3. Have you ever been asked to surrender your license? □ Yes □ No □

☐ Additional information is attached for the above section (questions ___, ____, ___)

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4. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example Medicare, CHAMPUS, or Medicaid)? □ Yes □ No
5. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program? □ Yes □ No
6. Has your federal or state narcotics registration certificate ever been relinquished, limited, denied, suspended, or revoked? □ Yes □ No
7. Is your federal or state narcotics registration certificate currently being challenged? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ____, ___)

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8. Have you ever been named as a defendant in any criminal proceedings? □ Yes □ No
9. Has your employment, Medical Staff appointment, or clinical privileges ever been suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily? □ Yes □ No
10. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before the hospital or health facility's Board made a decision? □ Yes □ No
11. Have you ever been the subject of focused individual monitoring at any hospital or health care facility? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ____, ____)

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12. Have any profession liability claims or suits ever been filed against you or are any presently pending? □ Yes □ No
13. Have any judgments or settlements been made against you in professional liability cases? □ Yes □ No
14. Had your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? □ Yes □ No
15. Has any information pertaining to, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___, ___)

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16. Do you have any financial interest (directly or through family or business partners) in any nursing home, laboratory, pharmacy, medical equipment, or supply house or other business to which patients from the CDCR might be referred or recommended?
17. Are you able to perform all the services required by your agreement with, or the professional bylaws of, the Division of Correctional Health Care Services to which you are applying, with or without reasonable accommodation, according to the accepted standards of professional performance and without posing a direct threat to the safety of patients? □ Yes □ No
18. Did you change medical schools and/or residency programs? □ Yes □ No
19. Does your curriculum vitae show any gaps in training or practice greater than 3 months in duration? □ Yes □ No
20. Have you ever been examined by any specialty board and failed to pass the examination? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___, ___, ___)

FOR QUESTIONS 21, AND 22, PROVIDE ADDITIONAL INFORMATION ON A SEPARATE PIECE OF PAPER WHEN DIRECTED TO DO SO AS A RESULT OF YOUR ANSWER

21. If not currently certified, have you applied for:
- ☐ **Physician's Assistants**: National Certification? □ Yes □ No
- ☐ **Physicians**: Family Medicine or Internal Medicine: □ Yes □ No
- ☐ **Nurse Practitioners**: Adult or Family Medicine: □ Yes □ No.

If not, do you intend to apply for the relevant certification exam? □ Yes □ No.
If no, please explain why on a separate piece of paper. ☐ Additional information attached.

22. Have you been accepted to take the relevant certification exam? □ Yes □ No
If yes, what dates are/were you scheduled to take the certification exam?

APPLICANT'S AUTHORIZATION AND RELEASE

I hereby attest that the information in or attached to this application is true and complete. Any misrepresentation, misstatement, or omission from this pre-application, whether intentional or not, may constitute sufficient cause for rejection of this pre-application resulting in denial of provisional clinical privileges.

I hereby authorize the CDCR, its medical staff, and their representatives to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association, or privileges and any other organizations (including without limitation state licensing boards, professional associations, and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records that shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting as well as to my moral and ethical qualifications.

I authorize and request my medical malpractice liability insurance carrier, past and present, to release information to the CDCR, its medical staff, and their representatives regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

I hereby release from liability all individuals and organizations that provide said information to the CDCR, medical staff, and their representatives in good faith and without intentional fraud, and I hereby consent to the release of such information.

A photocopy of the release shall be valid as an original. This is a request to obtain additional information, not a commitment to hire.

Please Note: This authorization shall expire upon separation from CDCR or within twelve months of the date below, in the event that no employment is offered and accepted.

_____ _____

Signature of Applicant Date

PRIMARY CARE CLINICAL PRIVILEGES

Name: _____
Effective From ____/____/_____ To ____/____/_____

☐ Initial Appointment

Applicant: Check off the "Requested" box for each privilege requested. New applicants may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Division of Correctional Health Care Services (DCHCS) for a proper evaluation of current competence, and other qualifications and for resolving any doubts.
Professional Practices Executive Committee (PPEC) Chairperson or Designee: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Qualifications for Primary Care

Initial Applicant - To be eligible to apply for core privileges in Primary Care, the applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited three-year post-graduate training program in internal medicine or family medicine.
AND
Current certification or active participation in the examination process leading to certification in internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine or family medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Physicians.
Required Previous Experience: Initial applicants must be able to demonstrate provision of inpatient or outpatient services to at least 100 patients in the last 24 months or demonstrate successful completion of a hospital-affiliated accredited residency, special clinical fellowship within the last 24 months.

Core Privileges

Primary Care Core Privileges

☐ Requested

Admit, evaluate, diagnose, treat and provide consultation to adult patients with common and complex illnesses, diseases, and functional disorders. Manage and/or stabilize trauma and critically ill patients. These services can be rendered in the inpatient and outpatient settings. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

Special Non-Core Privileges (See Qualifications and/or Specific Criteria)
Criteria: Successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship or other acceptable experience, and documentation of competence to obtain and maintain clinical privileges as set forth in medical staff policies governing the exercise of specific privileges.

Lumbar Puncture

☐ Requested

Criteria: Successful completion of an accredited residency that included training in lumbar puncture, or the applicant must have completed hands-on training in lumbar puncture under the supervision of a qualified physician preceptor.

Required Previous Experience: Demonstrated current competence.

Maintenance of Privilege: Demonstrated current competence

PRIMARY CARE CLINICAL PRIVILEGES

Name: _____
Effective From ____/____/_____ To ____/____/_____

Exercise Testing

☐ Requested

Criteria: Successful completion of either of the following: an accredited residency and evidence that the training included participation in exercise procedures.

Maintenance of Privilege: Demonstrated current competence and evidence of performance of at least 10 exercise tests for the past 24 months.

Core procedure List

Note*: This list includes only those procedures that are required of all primary care providers. It is not intended to be an all-encompassing list.*

Primary Care Core Procedure List

- Basic Cardiac Life Support
- Peripheral venipuncture
- Peripheral intravenous lines
- Local infiltration anesthesia
- Laceration repair
- Treatment and removal of skin lesions
- Nail removal
- I&D of simple abscess
- Splinting
- Initial interpretation of x-rays pending review by radiologist
- Basic EKG interpretation
- Perform PAP smears, vaginal and cervical cultures

PRIMARY CARE CLINICAL PRIVILEGES

Name: _____ Page 3
Effective From ____/____/_____ To ____/____/_____

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at California Department of Corrections and Rehabilitation (CDCR) Institutions, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by CDCR, DCHCS, and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed_____ ***Date***_____

PPEC Chairperson or Designee Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

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_____
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PPEC Chairperson or Designee Signature_____ ***Date***_____
PPEC Chairperson or Designee Name (print) _____

FOR CREDENTIALING COORDINATION UNIT USE ONLY

Professional Practices Executive Committee Action_____ ***Date***_____